Observations on the Bill to remove the mandatory waiting period from the Health (Regulation of Termination of Pregnancy) Act 2018

Summary, Irish Family Planning Association (IFPA), August 7th, 2026

The Irish Family Planning Association (IFPA), Ireland's leading not-for-profit sexual and reproductive health provider, supports the proposed removal of the mandatory three-day waiting period under Section 12(3) of the Health (Regulation of Termination of Pregnancy) Act 2018. Drawing on our clinical experience, service data, national research and international guidance, the IFPA concludes that the requirement has no medical rationale, provides no demonstrated benefit and creates avoidable barriers to timely healthcare.

A mandatory waiting period should not be confused with informed consent. Patients should receive comprehensive information, have their questions answered and take whatever time they personally need. The current law instead imposes an arbitrary delay on everyone, implying that pregnant women cannot be trusted to make informed healthcare decisions.

The requirement can cause anxiety, distress, additional expense and unnecessary travel. Weekends, public holidays, ultrasound appointments and hospital referrals may extend the delay beyond three days. Combined with the rigid 12-week gestational limit, this can cause patients to become ineligible for care in Ireland or require hospital treatment or travel abroad. Rural, low-income and marginalised patients are particularly affected.

The evidence reviewed is consistent. The O'Shea Report found no established benefit from compulsory delay and documented its practical and psychological burdens. Irish studies show that service users generally make their decisions before contacting a provider, while healthcare professionals overwhelmingly regard the requirement as unnecessary, paternalistic and obstructive. The World Health Organization recommends removing medically unnecessary legal and procedural barriers to abortion, while the UN Committee on the Elimination of Discrimination against Women has called on Ireland to abolish the waiting period and consider full decriminalisation. IFPA data also provides no evidence that the waiting period changes pregnancy decisions.

Internationally, Ireland is increasingly an outlier: 29 of the 43 European countries permitting abortion on request impose no mandatory waiting period, and several European states have recently repealed similar requirements. Removal would not diminish counselling, clinical assessment or support for informed consent. Patients should continue to receive confidential information, specialist counselling, telemedicine where appropriate and as many appointments as they need—but according to their own needs and chosen timeframe. Removing the mandatory waiting period would align Irish law with clinical evidence, international best practice and rights-based, person-centred healthcare while preserving all appropriate safeguards for informed decision-making.

IFPA recommendations

1. Delete Section 12(3) in its entirety, without replacing it with a statutory "right to reflection."
2. Expand the definition of authorised healthcare providers to include nurses and midwives.
3. Extend the 12-week limit where healthcare-system delays, failed treatment or similar circumstances would otherwise make a patient ineligible.
4. Undertake a wider review of the gestational limit and associated barriers.
5. Review and reform the Act's health and fetal-anomaly provisions.
6. Commit to the full decriminalisation of abortion, consistent with WHO and CEDAW recommendations.

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Appendices

1. About the IFPA

The Irish Family Planning Association (IFPA) is Ireland's leading not-for-profit sexual health organisation. We promote the right of all people to sexual and reproductive health information and dedicated, confidential and affordable healthcare services.

The IFPA was established in 1969, at a time when its founders were motivated by the harms to health and the damaging social and economic impacts of the ban on contraception. Since then, the organisation has been to the fore in setting the agenda for sexual and reproductive health and rights, both nationally and internationally.

We work for the right of everyone to access to the highest attainable standard of health, without coercion, discrimination or violence. We do this by engaging in advocacy, promoting gender equality and by delivering on our mission to provide high-quality, inclusive healthcare with a particular focus on those facing multiple and intersecting forms of discrimination, ensuring that no one is left behind.

At our two Dublin clinics and nationwide network of counselling centres we provide contraception and abortion care, cervical screening, STI testing and treatment, a service for survivors of female genital mutilation (FGM) and specialist sexual and reproductive health counselling. We deliver training to medical and social care professionals. We provide a highly regarded online accredited contraceptive training course for medical professionals and sexual health training to service providers, young people, parents and community groups.

The IFPA's vision is of a world where everyone has equitable access to the highest standards of sexual and reproductive healthcare and where their sexual and reproductive rights are respected and fulfilled. We champion sexual and reproductive health and rights by providing specialist services, engaging in advocacy and promoting gender equality. We work from a human rights perspective to influence sexual and reproductive health and policy.

As a member association of the International Planned Parenthood Federation (IPPF) and the Irish collaborating partner of UNFPA—the United Nations agency for sexual and reproductive health and rights, we connect with global efforts to fight for SRHR for all.

We work with healthcare professionals and civil society in Ireland and internationally to share knowledge and create forums to highlight the impact of restrictive SRHR laws and discuss pathways towards reform.

Note on language

At the IFPA, we strive to use gender-neutral language and inclusive terms, both to capture the full spectrum of clients who access our services and to underscore our commitment to equitable access to the highest standards of sexual and reproductive healthcare for all. We work from a human rights perspective to influence sexual and reproductive health policy. This includes highlighting the impacts of policies on those who experience direct, indirect, structural and systemic discrimination and disadvantage. We therefore refer to women and girls, LGBTQI+ people, people with disabilities, migrants, etc. When we use a term to refer to specific categories of people, it is not intended to exclude others.

2. The mandatory waiting period: a non-health related barrier

2.1 Overview

The IFPA welcomes the opportunity to provide comment on the bill to remove the mandatory waiting period from the legal framework for abortion and to share our clinical experience and

data in this regard. There is no healthcare rationale for the three-day wait: in all other areas of healthcare, treatment is provided as soon as it is decided upon. Our submission includes appendices on international best healthcare practice, policy and rights; national and international research and public health evidence.

It also includes the IFPA's unique multi-year data on the impact and operation of the mandatory waiting period.[1] The big picture is consistently across the period of our study: 98% of the IFPA clients who were required by law to endure the mandatory waiting period in this period proceeded to access abortion care.

These perspectives unambiguously make the case for the removal of this legal barrier. We also provide some information on the current operation of the law and highlight our recommendations.

The inclusion of enforced delay in the legislation causes harm, because it is a non-health related barrier to healthcare and because it encodes a harmful gender stereotype into the law. Moreover, it undermines the spirit of the referendum which repealed the eighth amendment and the deliberative processes undertaken by the Citizens' Assembly and by the Joint Oireachtas Committee on the Eighth Amendment which paved the way for that reform.

As we outline below, the mandatory waiting period makes Ireland an outlier in Europe, in terms of reproductive health policy. Had the Oireachtas not included a mandatory waiting period in the 2018 legislation, enforced delay would not form part of the model of care. Healthcare providers would, appropriately, be guided by ordinary procedures regarding support for informed consent and could provide tailored support based on clients' needs and personal circumstances, rather than according to arbitrary legal rules.

As the IFPA's medical director, Dr Caitríona Henchion has stated: "If somebody is absolutely fully informed, has had whatever time they need, then I would respect that person's autonomy and say they've made their decision and they know what they want".[1]

The IFPA would welcome the opportunity for Dr Henchion and other key personnel to address the committee and share clinical experience of the operation of the mandatory waiting period, the IFPA's model of care and the implications of enforced delay in the IFPA's clinical practice.

The mandatory waiting period is by no means the only flaw in the 2018 act, but it is one that affects every single client who requests an abortion at less than 12 weeks gestation. The IFPA therefore urges the health committee to resume its consideration of the Independent Review of the Operation of the Health (Regulation of Termination of Pregnancy) Act 2018 (O'Shea Report), published in 2023 (hereafter the O'Shea report) and the wider recommendations therein.

We also urge the health committee to consider the mandatory waiting period in the context of early abortion care in the community setting more generally. Any discussion of the practical, procedural or organisational issues arising from its removal from the law would be incomplete without consideration of issue of provider restrictions. Currently, the law stipulates that the only healthcare professionals who are legally permitted to provide abortion are doctors. We note international best practice in the sections below and outline the impact of this in the relevant appendix.

2.2 Terminology

Section 12 (early pregnancy), subsection (3) of the Health (Regulation of Termination of Pregnancy) Act 2018 states that termination of pregnancy may not be carried out unless a

[1] This data relates to 4 years (2021-24). The 2025 data and the cumulative 5-year data will be published in the forthcoming IFPA Annual Report 2025, which we will share with the committee members.

period of not less than 3 days has elapsed from the date of certification.[2] In international human rights law, a provision of this kind is termed a mandatory waiting period. The word "mandatory" is critical: it indicates a period of time imposed by law for non-health related reasons. It is the established usage of the World Health Organization (WHO), of human rights expert bodies and of international human rights organisations.

For clarity and consistency, we urge the committee to use this term throughout its deliberations and to endeavour to avoid the use of terms such as "reflection period" or "cooling-off period". These terms can lead to a conflation of two very different things: on the one hand, a coercive legal measure which enforces delay without any healthcare rationale or medical indication, as in s.12 (3), and, on the other, informed consent, the established principle that people must be supported to make informed decisions about their healthcare. The latter is an ethical obligation on healthcare providers in Ireland and globally and it is detailed in the practice guidance that informs professional standards. Informed consent respects autonomy; a mandatory waiting period does the opposite.

2.3 A stigmatising measure

In the IFPA's clinical experience, the mandatory waiting period is stigmatising and causes material harms to those who need abortion care. It demeans every single person who seeks early abortion care under section 12 of the act by treating their request for a healthcare intervention, to which they are entitled, as inherently questionable. It causes delay, stress and distress and potentially unnecessary additional travel, time and expense. In the context of a rigid gestational limit, enforced delay can push people beyond 12 weeks and out of eligibility for care, forcing pregnant women and girls to travel outside Ireland and seek this essential healthcare in the unfamiliar system of another state. In doing so, they are burdened with significant costs, stress, distress and stigma.

The O'Shea report found no evidence that a compulsory delay benefits patients.[3] Barrister Marie O'Shea—who carried out the review into the operation of the 2018 legislation was clear about the physical and psychological burden on women, particularly if they are forced to travel abroad for abortion care, which can be a result of the mandatory waiting period: "If you have to send somebody abroad, culturally and socially you're framing it as a criminal and abhorrent act and that's in a person's head and I don't think the electorate would want somebody carrying around that stigma," she added. Ms O'Shea has stated that she received confirmation from the chief medical officer (CMO) that there is no medical need for such a provision.[4] The IFPA's medical director is also on record that there "is no scientific support for a mandatory waiting period for abortions in Ireland." [5]

2.4 No basis in the deliberative processes prior to the 2018 referendum

In the IFPA's view, the mandatory waiting period should not have been introduced into law or medical practice. This view is based on best practice standards for reproductive healthcare and international human rights law, specifically the content of the right to health. We also note that this measure was not recommended by the Citizens' Assembly or the Joint Oireachtas Committee on the Eighth Amendment, both of which made wide-ranging recommendations based on extensive evidence from Irish and international experts in rights-based healthcare. The mandatory waiting period was included in the general scheme of a bill to regulate termination of pregnancy [6] published in March 2018, as a political compromise and before the extent of public support for repeal of the eighth amendment was definitively established by the referendum.

2.5 An anomaly in healthcare

Medically unnecessary delays in law are unjustifiable barriers to timely access to healthcare, and, as such, the mandatory waiting period is an anomaly in contemporary healthcare. It is a

provision that applies to only one form of healthcare in ways that are gendered, discriminatory and stigmatising. Moreover, it is misaligned with the prevailing trend away from a paternalistic approach to healthcare and towards embedding human rights and autonomy into service provision and organisational culture.

The mandatory waiting period effectively encodes a presumption of poor decisional capacity or decisional uncertainty into the law: it places a burden on healthcare providers to explain a legal barrier which is outside of international best healthcare practice. It raises a presumption that pregnant women are inherently likely to make poor choices and of a risk of doctors rushing or pressuring them into a decision about abortion. There is no evidence to support either assumption.

The language used throughout the act frames access to abortion care as something that must be formally authorised and verified through a statutory process. This language reflects a legislative, rule-bound approach to healthcare, centring compliance with legal criteria rather than the pregnant person's needs, circumstances and autonomous decision-making and the health care provider's clinical experience and expertise. Law not only codifies and regulates, it influences and shapes attitudes and beliefs in ways that have material consequences for providers and individuals. By marking abortion out as requiring a special form of approval, such as certification, and by retaining criminal provisions, the act reinforces the perception that this care is exceptional or suspect. In doing so, the terminology used increases stigma for both patients and healthcare providers.

2.6 Policy cannot be frozen in time by law: need to refocus on health

The 2018 referendum empowered the Oireachtas to regulate abortion provision. In addition to legislation to provide for abortion care, the safe access zones legislation was enacted. Telemedicine was incorporated into abortion care during the pandemic, and, with domestic and international evidence of its safety and efficacy within the care pathway, has been retained. These measures demonstrate the state's commitment to evidence-based policy making and to its obligation to ensure progressive realisation of the right to the highest attainable standard of healthcare.

Abortion care is too often politicised, exceptionalised and stigmatised. The members of the health committee have an opportunity to show leadership by engaging in evidence-based health policy making: the proposed reform responds to evidence from Irish and international experts of the harms of the mandatory waiting period. It would be incongruous and out of line with the generally positive and person-centred trend in healthcare policy to leave section 12 (3) in place. We urge the committee to consider the evidence and support a reform that will bring Irish law more appropriately in line with evolving public health evidence, international best practice standards and rights-based, person-centred healthcare.

Health policy cannot be frozen in time by a law that was drafted before the full extent of public support was made clear in the referendum to repeal the 8th amendment. At that time, abortion care had only ever been provided in cases of risk to life. Since the introduction of abortion services in Ireland, a body of research and public health evidence has emerged, including academic and clinical research and national studies. No robust academic or scientific evidence has emerged in support of the mandatory waiting period's retention. The 2018 referendum empowered the Oireachtas to regulate abortion care: as a healthcare provider the IFPA urges this committee to engage in considered and purposeful reflection of the bill currently before it and respond appropriately to reform the law in line with the best interests of reproductive health.

3. International perspectives

3.1 World Health Organization

The World Health Organisation (WHO) 2022 *Abortion Care Guideline* recommends the removal of all legal and procedural barriers that delay or restrict access to abortion.[7] Medically unnecessary restrictions, i.e. legal requirements that are not clinically indicated, including the rigid gestation limit, the criminal provisions and the mandatory waiting period, have no place in modern laws. The WHO recommends that rather than regulating access through arbitrary legal thresholds, abortion care should be provided according to the pregnant person's informed decision and clinical need.

Furthermore, the WHO recommends removal of provider restrictions as an important step in increasing access and the optimisation of the healthcare workforce. The WHO's 2022 guidance refers to evidence that shows that restrictions on who can provide and manage abortion resulted in delays to and burdens in accessing abortion. By contrast, expanding the range of health workers who can provide abortion care improved timely access to early medical and surgical abortion; reduced costs, travel and waiting time; shifted components of care away from physicians; made abortion more available including in rural areas and at primary health care level; prevented unsafe self-management of abortion; and reduced system costs.[8] This is echoed by the O'Shea report, which recommend removal or provider restrictions "to address barriers to service delivery by the low numbers of medical practitioners willing to provide the service and to ensure that service is not dependent on a handful of health workers operating in small teams across the primary and hospital setting".

3.2 United Nations

The United Nations Committee on the Elimination of Discrimination against Women (CEDAW), which oversees states' fulfilment of their obligations to promote and achieve gender equality, regularly criticizes governments for imposing undue barriers to healthcare that women need. In July 2025, CEDAW called on the Irish government to "consider fully decriminalizing abortion and abolishing the mandatory three-day waiting period."[9]

3.3 Trends in European and other laws

According to a 2025 report by the Center for Reproductive Rights,[10] the overwhelming trend in Europe is towards the repeal of legal provisions imposing a mandatory waiting period prior to abortion. Ireland is part of a clear minority of countries in Europe that continue to impose mandatory waiting periods before abortion care can be provided. Of the 43 European countries that allow abortion on request, 29 do not impose any form of mandatory waiting period on pregnant people who seek abortion care. Beyond Europe, women and girls in South Africa, Colombia, Mexico, Canada and Australia do not have to endure a mandatory waiting period.

Ireland is an outlier, both in having a mandatory waiting period and in the rigidity of its application. If this bill is passed, Ireland will join a number of European countries that have eradicated mandatory waiting periods in recent years: North Macedonia (2019), France (2022), Spain (2023), Netherlands (2023) and Luxembourg (2025).

4. Public health evidence

4.1 International and domestic data and analysis

As a healthcare provider, the IFPA is committed to evidence-based healthcare policy and law-making. We draw upon the research, analysis and best practice guidance of the leading global healthcare expert bodies, including UNFPA, the United Nation's agency for sexual and reproductive healthcare and the World Health Organization; European Society for Contraception and Reproductive Health; the Royal College of Obstetricians and Gynaecologists; and the UK Faculty of Sexual and Reproductive Health.

We are also influenced by Irish research since the introduction of abortion care in 2019. A research project supported by the WHO in 2020 found that "both GPs and service users believed that the mandatory three-day wait is unnecessary and can lead to delays."[11] A study by the Abortion Rights Campaign detailed its negative psychological impact on service users both psychologically and as the reason for travel overseas because of 'timing-out'. [12] The HSE's national unplanned pregnancy and abortion care (UnPAC) study of patient experiences of abortion care found that very few participants considered the three-day wait to be of any personal benefit to them.[13] The associated Department of Health study of provider perspectives recommended its reform: "from a service provider perspective, the waiting period has resulted in applications for termination of pregnancy falling within the legally permitted pathways 'timing-out' of care".[14] Research by medical practitioners also stated the negative impact of the waiting period, describing it as '"presumptive and patronising" as it suggests pregnant people are not certain of their decision (Mullaly et al., 2020). Recent research into providers' experiences of provision of abortion care by leading medico legal experts at UCC echoed this finding and reported "notable uniformity" in responses to the mandatory waiting period, with a substantial majority of providers finding it problematic, because of "the inherently paternalistic nature of the requirement" and the "practical problems which the wait created for women."[15]

We also produce our own internal data analysis and share this with a view to enhancing public understanding of reproductive healthcare. For example, in 2019, the IFPA published Ireland's first data on early abortion care, based on an audit of the first six months of our service. In 2020, we shared insights from the experience of accessing telemedicine abortion during the Covid-19 pandemic.[16] We have contributed a body of analysis of Ireland's abortion laws before and after repeal to international medical journals.[17] In a succinct expression of the IFPA's view, expressed by former research and policy coordinator, IFPA's Alison Spillane, in a 2021 peer-reviewed article: "if a patient needs more time to think through their options, they are able to voice that decision for themselves."

Since 2021, we have been publishing annual data on our clients' experience of the mandatory waiting period. Our motivation was to enhance public understanding of its operation in the clinical context and to promote understanding of the critical distinction between a supportive approach to decision-making and a coercive legal barrier. We were also concerned at statements by leading politicians that reflected either misinformation or inadequate familiarity with the HSE model of care. Specifically, we believed it was important to provide information to counter persistent claims that (a) a significant number of women did not proceed to have an abortion after a first consultation and (b) this demonstrated a change of mind and a decision to continue a pregnancy. We have published this data in our annual reports, and it has been covered in most national broadsheets and on RTÉ. [18]

These claims are entirely at odds with our clinical experience and demonstrate lack of understanding of the HSE model of care and its requirements for hospital referral. Moreover, the assertions based on misguided conclusions about data have served to reinforced harmful

gender stereotypes about pregnant women's presumed decisional uncertainty and have been cited in support of unfounded assumptions about the influence of legally mandated delay.

To challenge such unscientific speculation, the IFPA undertook to engage in public health education by publishing annual data from our services. Our data insights are in line with the views and experiences of leading medical experts, and of the World Health Organisation, that an enforced waiting period before abortion care is unjustifiable, demeaning and patronising. There is nothing in our data to indicate that the enforced three-day wait influences decisions about pregnancy.

4.2 The review of the operation of the 2018 Act

The O'Shea Report describes the mandatory waiting period (MWP) as "contentious". In many interviews and in her presentation to the health committee, Ms O'Shea was unambiguous in her view of the waiting period as unwarranted. While acknowledging the argument that a reflection period may protect against hasty decisions or subsequent regret, the O'Shea report cites the World Health Organization's conclusion that the evidence has not established any benefit from mandatory waiting periods.

The report made clear that participants generally wished to access care promptly and had already reflected on their decision before contacting My Options or a healthcare provider. Their accounts were almost universally consistent in describing the mandatory waiting period as having little or no effect on their decision-making. Some considered it an infringement of reproductive autonomy which suggested that women could not be trusted to provide informed consent without a prescribed period of reflection. Providers reported similar concerns: START, which represents approximately 300 abortion-care providers, regarded the mandatory waiting period as a material barrier[19], while a separate study cited in the report found that all but one participating GP wanted the requirement removed or made optional[20].

The O'Shea Report identifies several practical consequences which align with the IFPA's clinical experience. Because abortion services do not operate 365 days a year, a nominal three-day wait may become four or five days where weekends or public holidays intervene. Delays may be compounded by the need to obtain an ultrasound, hospital referral or other treatment before the 12-week limit. This can result in women "timing out" of lawful care in Ireland or passing the threshold for managing a medical termination at home and requiring hospital treatment instead. It also associates the mandatory waiting period with additional anxiety, physical and psychological distress, travel and financial costs. These effects are particularly significant for people living in rural areas and for marginalised patients who may experience difficulties attending multiple appointments or remaining in contact with services.

The O'Shea report does not interpret non-attendance for a second appointment as in any way providing proof that the waiting period changed a woman's decision. The report cites a 2019 study of 27 general practitioners from the Southern Task Group on Abortion and Reproductive Topics (START)[21] which suggests that the reasons people did not attend after a first consultation likely included miscarriage, attendance at another provider, travel abroad or obtaining medication elsewhere. This is borne out by the IFPA's multi-year dataset.

The IFPA endorses Ms O'Shea's evidence-based analysis and her overall conclusion that the mandatory waiting period is an unnecessary and unacceptable infringement on access to healthcare. However, in our considered opinion, the only acceptable reform is its full removal from the act. We therefore cannot support her recommendation to replace the universal three-day mandatory waiting period with a duty on medical practitioners to advise each patient that they have a statutory right to a reflection period, exercisable at their own discretion. Our fixed

position is that this non-health related provision has no place in the law and should be repealed, as proposed in the current bill being examined by this committee. Healthcare providers should not be in the position of explaining a non-health related barrier in legalistic terms. The only non-health issues that should appropriately be explained by the healthcare provider is in relation to the rights to access quality care with dignity and respect for privacy, confidentiality and autonomy.

4.3 IFPA internal research: data makes the case for reform

From 2021–24 (inclusive), 2,390 individual clients were verified as having a first consultation for abortion with the IFPA. Within this set, 99 clients (4.1%) were identified as no longer needing abortion care due to miscarriage, ectopic pregnancy or a negative pregnancy test at their initial consultation. The waiting period did not apply to these clients, and they were excluded from further analysis.

The outcome for 104 clients (4.3%) was indeterminable, as they made no further contact with the IFPA after their first appointment. Because there was no way of knowing if the waiting period still applied to them, they were excluded from further analysis. The IFPA recognises this as a limitation of the research conducted.

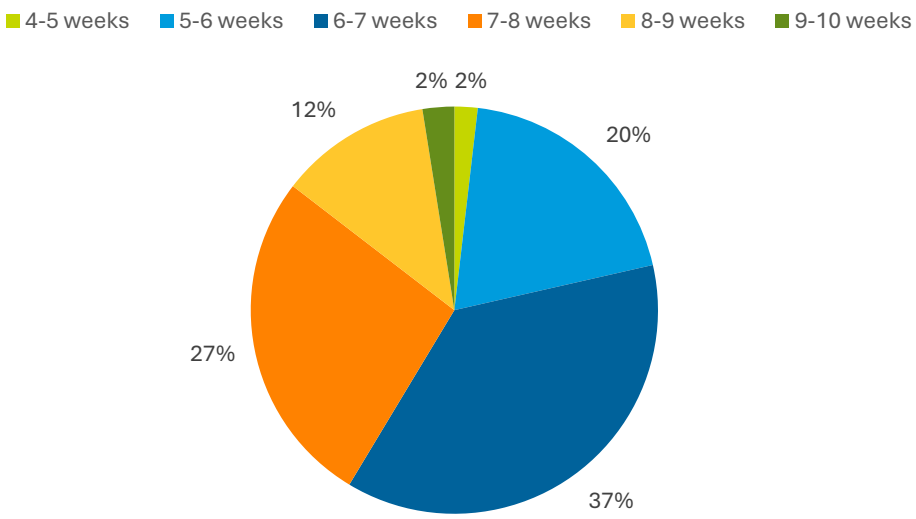
Of the remaining cohort of 2,187 clients who we verified as having been subjected to the mandatory waiting period, 98% (2,146 clients) proceeded to access abortion care. Their outcomes are summarised in fig. 1.

Fig. 1: Outcomes of clients verified as experiencing the mandatory waiting period 2021-24

Outcomes	Number of clients	Percentage
Accessed early medical abortion with the IFPA	1,936	88.5
Accessed hospital-based or GP abortion services	210	9.6
Continued pregnancy	41	1.9
Total	**2,187**	**100**

Analysis of our anonymised abortion service data for 2024, the most recent study of our service data at the time of writing, shows that most clients (85%) who accessed early medical abortion at the IFPA that year presented under eight weeks gestation; 15% were between eight and ten weeks.

Fig. 2: Early medical abortions at IFPA clinics by gestation period 2024



4.4 Global study of factors that influence decisions about parenting

The 2018 act reflects both political and healthcare considerations and encodes a tension between respect for autonomy on the one hand and distrust of women and doctors on the other. One of the autonomy-focused provisions is that no one is required to justify or provide a reason for their decision to request a section 12 early abortion. This respects privacy. However, this respect is undermined by subsection (3), which assumes that this decision is inherently and, in all cases, so uncertain that the law must force every single person who requests abortion to wait for three days.

The state has a legitimate interest in reducing the incidence of unintended pregnancy and improving access to reproductive healthcare. While we cannot make definitive statements about why people opt not to continue a pregnancy, a recent (July 2026) study by UNFPA provides the most robust available evidence on demographic change, fertility and family life; and young adults' hopes and decisions about relationships, parenthood and the future. Lives, Choices and Futures, UNFPA's report on the findings of the 2025-2026 Demographic Futures Survey[22] brings together one of the most geographically diverse bodies of evidence, drawing on the experiences of over 108,000 internet-connected people aged 18 to 39 across 73 countries.

These findings are not nationally representative and should not be interpreted as population-level estimates. Instead, the data tells us what these young adults value, what they worry about, what they see as important for partnership and parenthood and what conditions they report as shaping their choices. This report shows that many young people continue to value partnership and parenthood, but the conditions to realise these aspirations often feel out of reach.

The findings reveal that more than two thirds of respondents want to marry or live with a partner, and that two children is the most reported ideal family size in five out of seven regional groupings.

Economic and housing constraints constitute the most common obstacles to forming partnerships. Financial security is the top consideration for entering a partnership (81%) and parenthood (88%). Young respondents also consider stable employment (87%) and emotional readiness (85%) as important preconditions for becoming parents.

These map closely onto the factors suggested in the recently published Termination of Pregnancy Services in Ireland Report 2019-2025, which comments on likely social determinants of abortion decisions, including economic pressures such as the cost-of-living crisis and financial insecurity, demographic shifts and improved access to termination of pregnancy services.[23]

We include reference to these reports because they highlight an obvious point: one of the reasons why the mandatory waiting period is described by healthcare experts as "condescending" and "paternalistic" is that decisions about parenting are influenced by personal circumstances, including aspirations for the future, but also by national and global social, economic and political factors, of which people are acutely conscious of at the time of seeking an abortion consultation, and which are outside of their control.

4.5 WHO and UNFPA policy recommendations

What people need are social policies that support informed choices and create an environment in which people can plan families with confidence. From the IFPA's perspective, this requires a reproductive justice approach—i.e. state policies that support reproductive autonomy; this includes, of course, social policies as well as specific health policies. Among the latter, expanding access to the free contraception scheme to everyone who needs it, including under-17s, is a critical policy intervention.

The WHO abortion guidance makes clear that if governments want to prevent unintended pregnancies, the way to do it is by providing a comprehensive package of sexuality education, accurate family planning information and services and access to quality abortion care. From a provider perspective, free, accessible services where people can receive expert information from a healthcare professional while considering their options are the most effective support for informed decision-making.

UNFPA's Lives, Choices and Futures provides vital evidence to inform global policy discussions on demographic change, reproductive rights and sustainable development. The findings affirm that long-term investments in young people and cross-sector policies on education, employment security, housing, reproductive health services, and social protection will help them contribute to societies that are innovative, resilient and economically robust.

5. Service implications of repeal of section 12 (3)

5.1 Current model of care

The IFPA's current procedures are as follows: the abortion care process begins with our receptionists, who provide information about the care pathway, including the availability of free specialist pregnancy counselling. Doctors take a relevant medical history and explain everything a client needs to know about the abortion process, taking time to answer questions and ensure understanding. If a client is 9 weeks pregnant or less, they can continue their care with the IFPA and have an early medical abortion at home. Clients between 9 and 12 weeks are referred to hospital-based abortion services, in line with HSE guidelines. At the second appointment, the doctor clarifies any remaining questions. The client then can then take the first medication in the clinic and receive a home care pack which includes the second medication and information materials so that they can manage the abortion at home. After two weeks, clients take a low sensitivity pregnancy test to confirm the abortion is complete. The last stage is a final check-up call from one of our nurse-midwives.

The IFPA provides free, confidential and non-directive specialist counselling for pregnant women and their partners. This is funded by the HSE Sexual Health Programme and available at any time during a pregnancy, including before or after an abortion or if a person chooses to parent. At any point, any client can avail of HSE-funded specialist counselling from one of the IFPA's accredited counsellors.

From the IFPA's perspective, apart from cases when the coercive three-day mandatory waiting period and rigid gestation limit pose barriers to access to care, this works well. Patients are not under pressure to make a rushed decision while simultaneously trying to raise funds, organise travel, childcare and a cover story, as people were prior to repeal. Moreover, most people now feel safe discussing their situation with their support group of family or friends, and isolation or the need for secrecy are not the overwhelming issues they were before.

5.2 Impact of removing the mandatory waiting period

In the IFPA's view, the repeal of the mandatory waiting period has the potential to enhance the quality of care if the core elements of good practice that have developed since 2019 are retained: professional support to discuss their pregnancy, their options, the abortion process and, if so desired, contraception, in a confidential healthcare setting with qualified and experienced healthcare professionals, either in person or via telemedicine, at no cost to the pregnant person and with the option of free specialist pregnancy counselling if desired.

Clients must not experience any diminution in access to healthcare providers or support for informed consent. They must be able to attend as many appointments as they need, as in the current model.

The impact of removing the mandatory waiting period is that they will be able do so within a timeframe which is of their choosing and which conforms to their specific needs and circumstances. And, critically, they will not be made to feel the stigma of being informed that their treatment must be delayed by law for non-health related reasons.

However, a significant flaw in the law is the exclusion of midwives and nurses from the definition of health professionals who can provide abortion care. In terms of modern healthcare practice, this makes no sense and increases the burden on doctors because of legislative wording, rather than legitimate policy considerations. The efficiency of the model of care would be greatly enhanced by the inclusion of nurses and midwives. Currently, the definition of healthcare providers in the act is limited to doctors. In all other aspects of reproductive healthcare, midwives and nurses are the primary care providers. For example, in the IFPA, among our midwifery team are colleagues who are qualified to perform insertion and removal of intrauterine devices, provide anaesthesia and prescribe medication.

6. Recommendations

1. ***Delete section 12 (3) in its entirety***

In the IFPA's view, only the complete deletion of the subsection will address the harms of the mandatory waiting period.

2. ***Expand the definition of healthcare providers to include midwives and nurses***

We are conscious that the remit of the committee at this time is not a complete overhaul of the legislation, but as committee members take a laser-like focus on the mandatory waiting period,

we urge you to also discuss the ways in which the mandatory waiting period is linked with other provisions and consider additional reforms.

The Department of Health should consider amending the legislation to expand the range of health professionals who may provide termination of pregnancy services and should liaise with the professional bodies in relation to provision of training and education.

3. Reform of the gestation limit as per the O'Shea report

The main obstacle to considered decision-making that can be resolved by legislators is the rigid 12-week gestation limit. As our data shows, the vast majority of clients access care well within the 12-week cut-off. However, those whose pregnancy becomes a crisis close to the cut-off for personal or health reasons, or who are unaware they are pregnant, or who have not been able to access healthcare, are under enormous pressure to make a decision. The O'Shea report recommends a specified extension of the 12-week limit where healthcare-system delays or failed treatment or the mandatory waiting period would otherwise cause a patient to become ineligible for care.

4. Undertake to consider wider reform of the gestation limit

The mandatory waiting period is not the only provision that skews the legal framework away from international best practice standards. The World Health Organisation (WHO) 2022 Abortion Care recommends full decriminalisation and the removal of all legal and procedural barriers that delay or restrict access to abortion. Medically unnecessary restrictions have no place in modern laws.

The WHO is clear that a restrictive gestational age-limit, such as that in the 2018 act, can impede timely access to care without improving safety or clinical outcomes and should be repealed. If governments want to prevent unintended pregnancies, the way to do it is by providing a comprehensive package of sexuality education, accurate family planning information and services and access to quality abortion care.

5. Undertake a review of the health and fetal anomaly provisions

The O'Shea report makes a series of recommendations in this regard, including to convene stakeholders, including medical practitioners and other relevant healthcare professionals; patient representatives; lawyers and ethicists, to obtain a better understanding. The health committee has endorsed the O'Shea report but has not given it further consideration to date. We strongly urge the committee to undertake a programme of work in this regard.

6. *Commit to full decriminalisation of abortion*

The WHO has made clear that criminal provisions have no place in modern healthcare laws. WHO recommends the repeal of criminal provisions. The United Nations CEDAW Committee also highlighted this point in its July 2025 concluding observations to Ireland. Bad faith actors who induce or coerce a pregnant person to end a pregnancy outside the 2018 act should be prosecuted for assault aggravated by the pregnancy; in this way the gendered harm to the pregnant person would best be acknowledged.

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Termination of pregnancy services in Irish general practice from January 2019 to June 2019

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